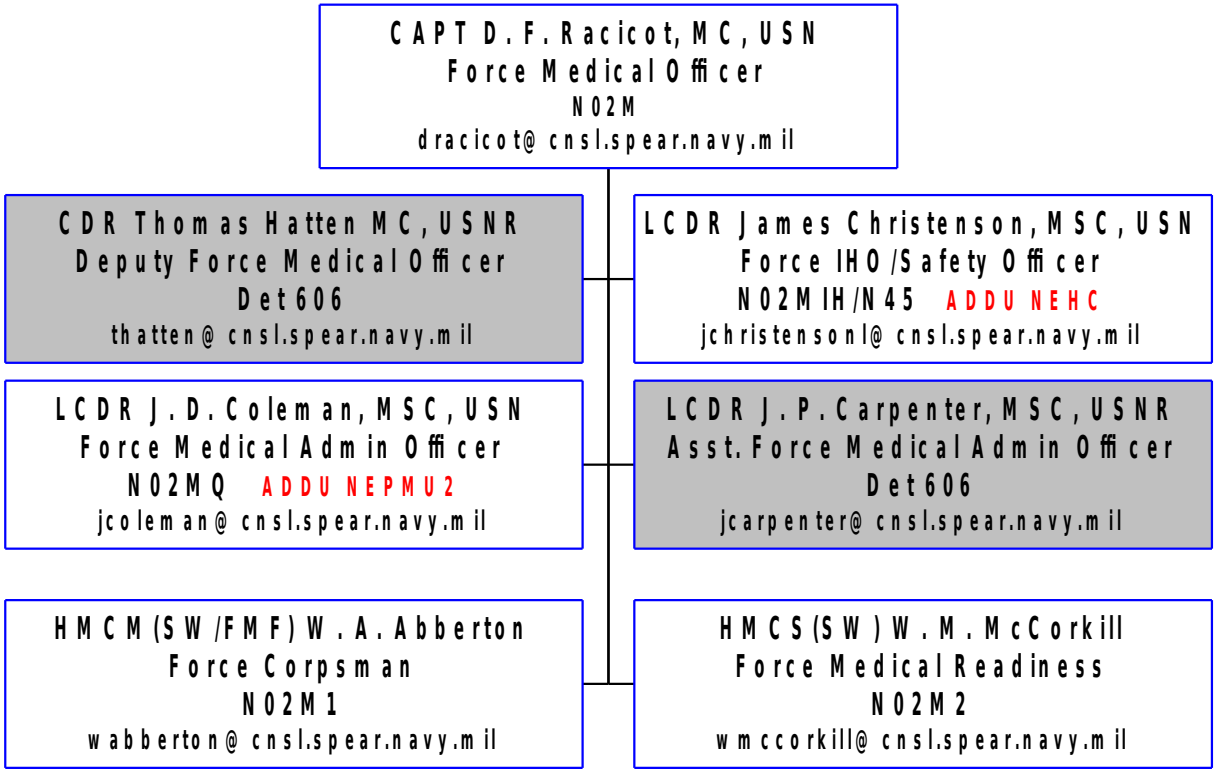
COMNAVSURFLANT

FORCE MEDICAL BRIEF

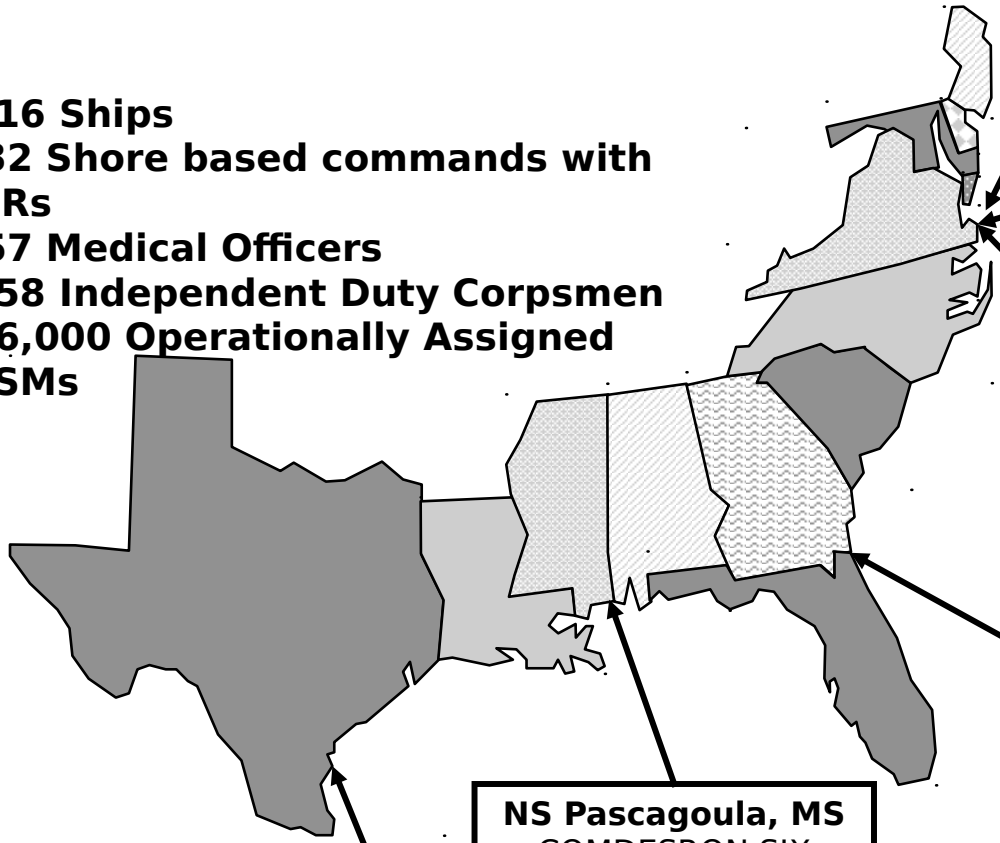
(UNCLAS)

Force Medical Staff



Medical ISICs

- **116 Ships**
- **32 Shore based commands with MDRs**
- **57 Medical Officers**
- **158 Independent Duty Corpsmen**
- **56,000 Operationally Assigned ADSMs**



NNSY Portsmouth, VA
COMSG TWO

NS Norfolk, VA
WSU
COMLOGGRU TWO

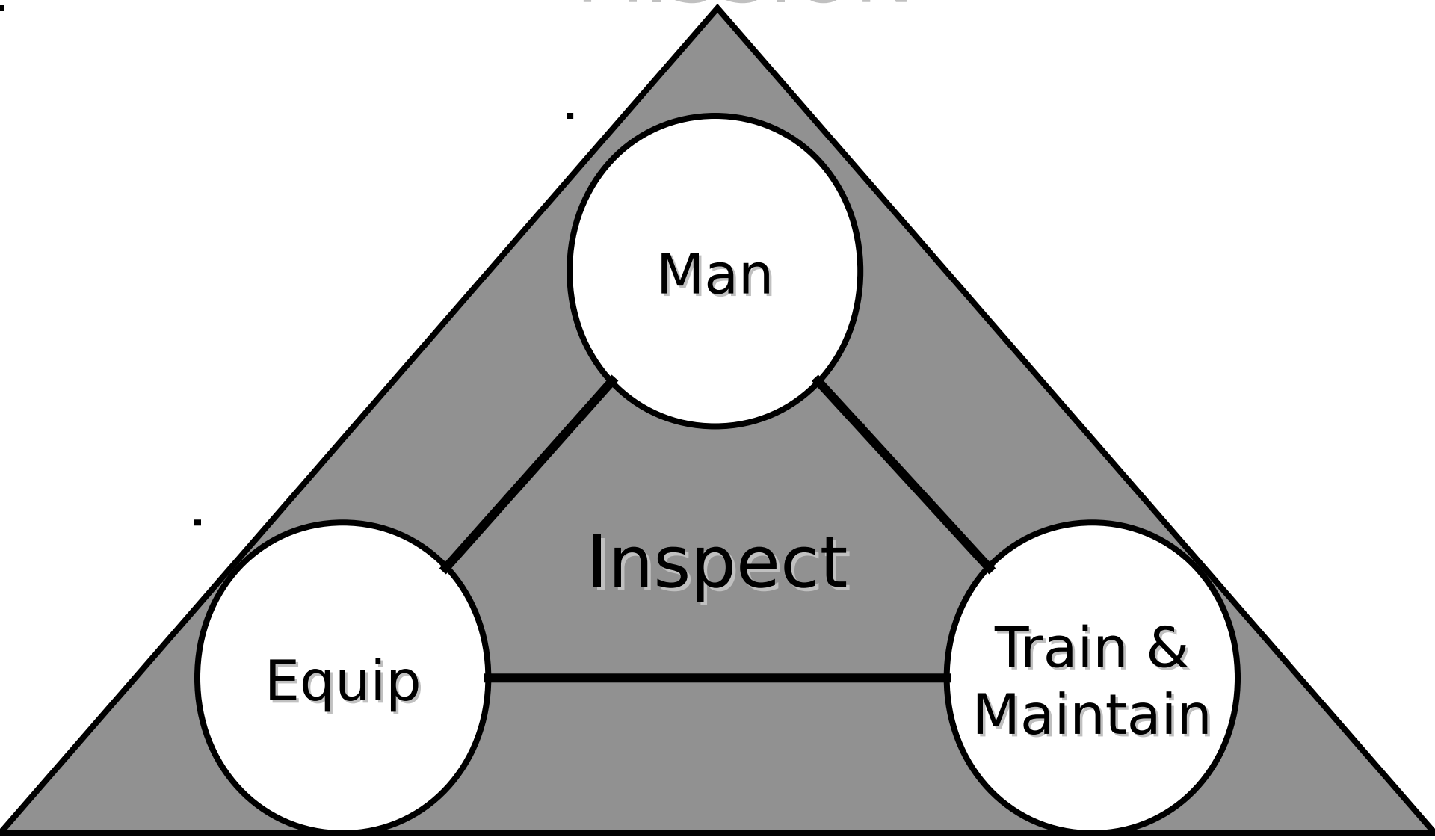
NAB Little Creek, VA
COMPHIBGRU TWO
COMEODGRU TWO

NS Mayport, FL
WSU

NS Pascagoula, MS
COMDESRON SIX

NS Ingleside, TX
COMINEWARCOM

COMNAVSURFLANT MISSION



Manning

- Ensure care for 56K operationally assigned Active Duty Service members (ADSMs)
- Validate Medical Manning requirements
  - Manage unplanned losses
  - Coordinate professional training & transition

Equipping

- SERP - Shipboard Equipment Replacement Program
  - NAVSEA Funds - phased replacement - > $5K
- TOB – Technical Operating Budget Funds
  - AMMAL & ADAL Changes
- OPTAR Advances & Augments
  - Unfunded & Mission requirements
- Fleet Prime Vendor Contract
- FISC Medical Representative

Training

- Medical Augmentation Personnel (MAP) Training Course
- PCO/PXO Course -Prospective Commanding Officer / Executive Officer Brief
- SWMOIC - Surface Warfare Medical Officer Indoc. Course
- IDC REFTRA -Independent Duty Corpsman Refresher Training Course

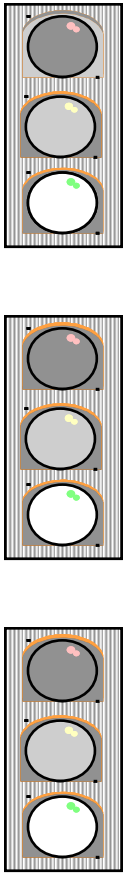
Force Readiness Directives

- Shipboard Medical Procedures Manual COMNAVSURFORINST 6000.1
- Medical Officer & Independent Duty Corpsman Process Assessment Improvement Reviews

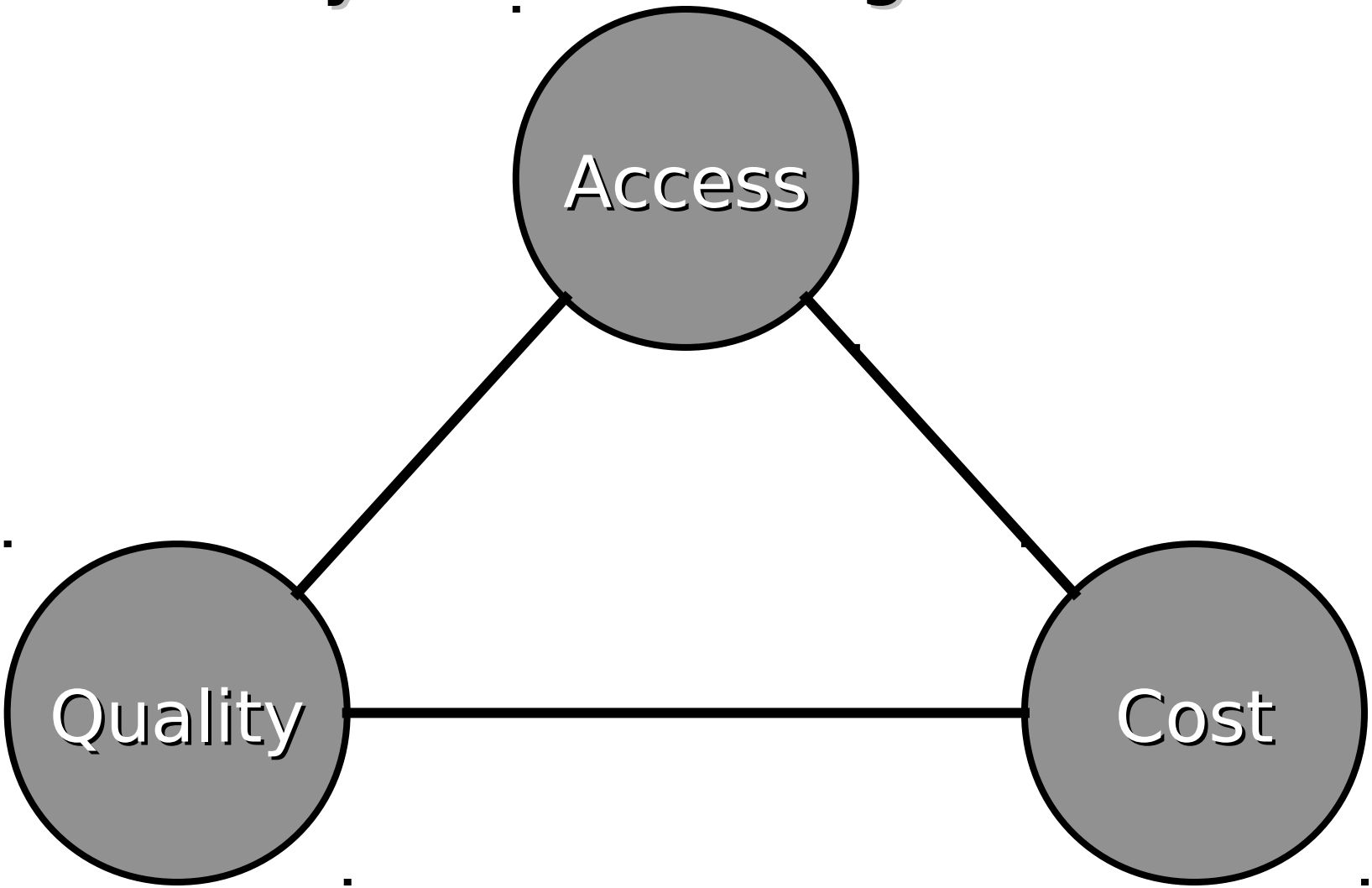
  COMNAVSURFORINST 6320.1B
- Medical Readiness Inspections CINCLANTFLT/CINCPACFLT INST 6000.1

Readiness Dashboard

- IMR
  - Immunization reporting
    - Click on “red” light
    - Current status click on green light
- AMMAL
  - Percentages
    - Click on “yellow”
- Readiness Status
    - Click on “yellow”



Healthcare Integration / Systems Management

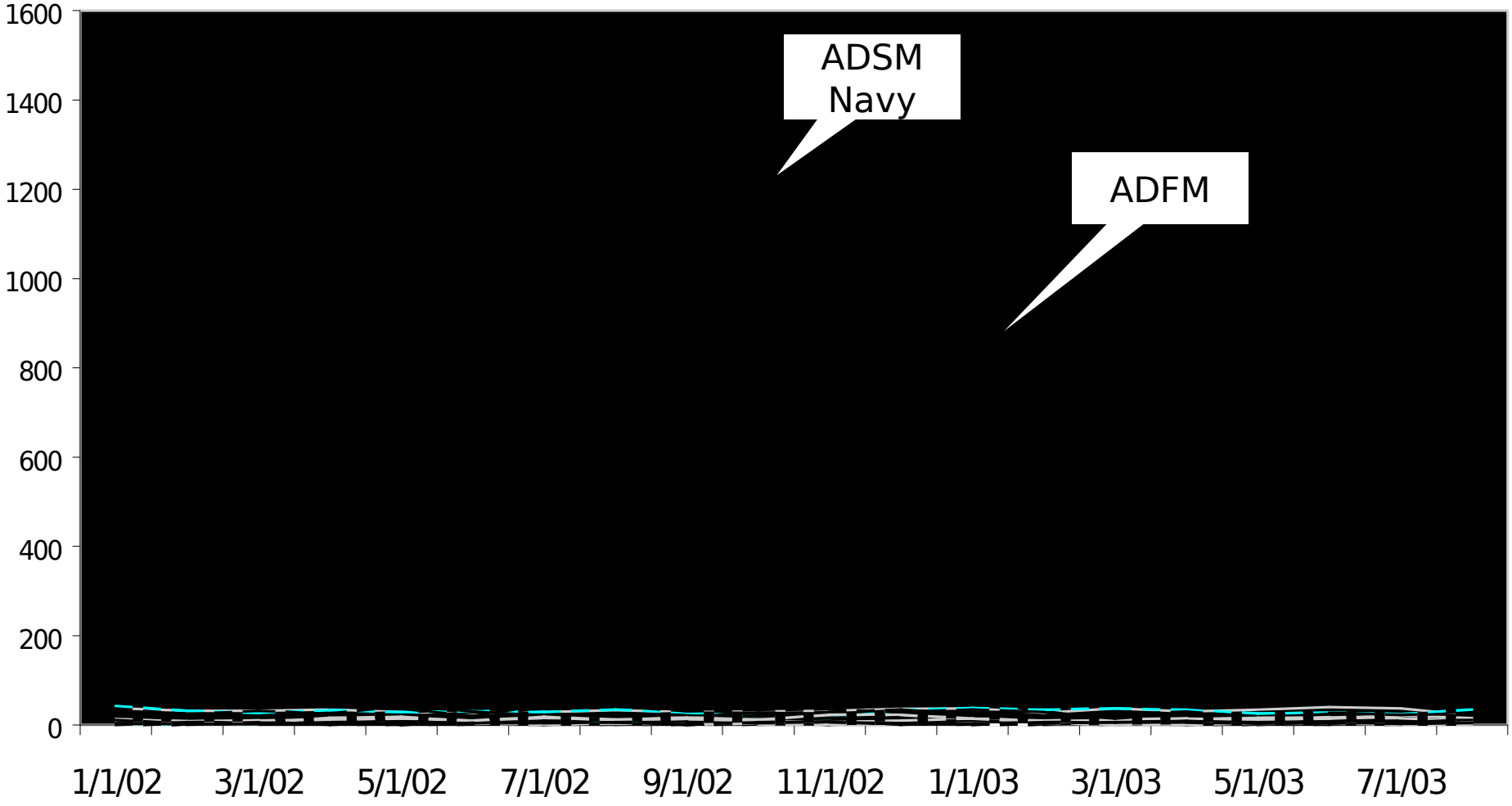


Operational Forces Enrollment: Control of Cost, Quality & Access

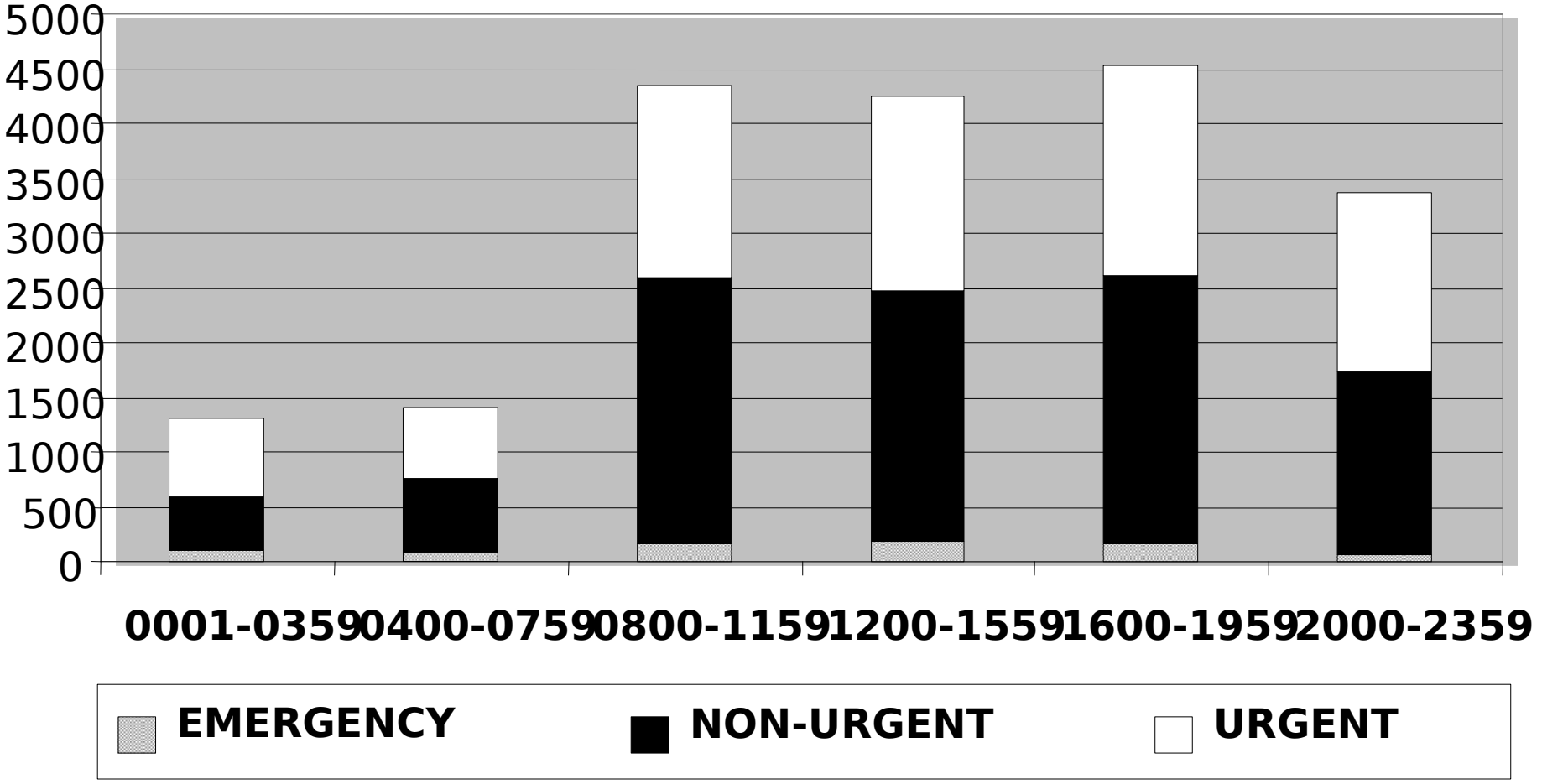
Uniform benefit is not provided to the operationally assigned ADSM:

- No policy/standardized process for enrollment
- No assignment of responsibility for primary care.
- No mechanism to ensure direct care system control of primary and referral/specialty care
- Operational Unit Senior Medical Department Rep is not recognized as Primary Care Provider (PCP)
- There is no mechanism to ensure patient encounter information is fed back to Operational PCP

Access: EMD Usage

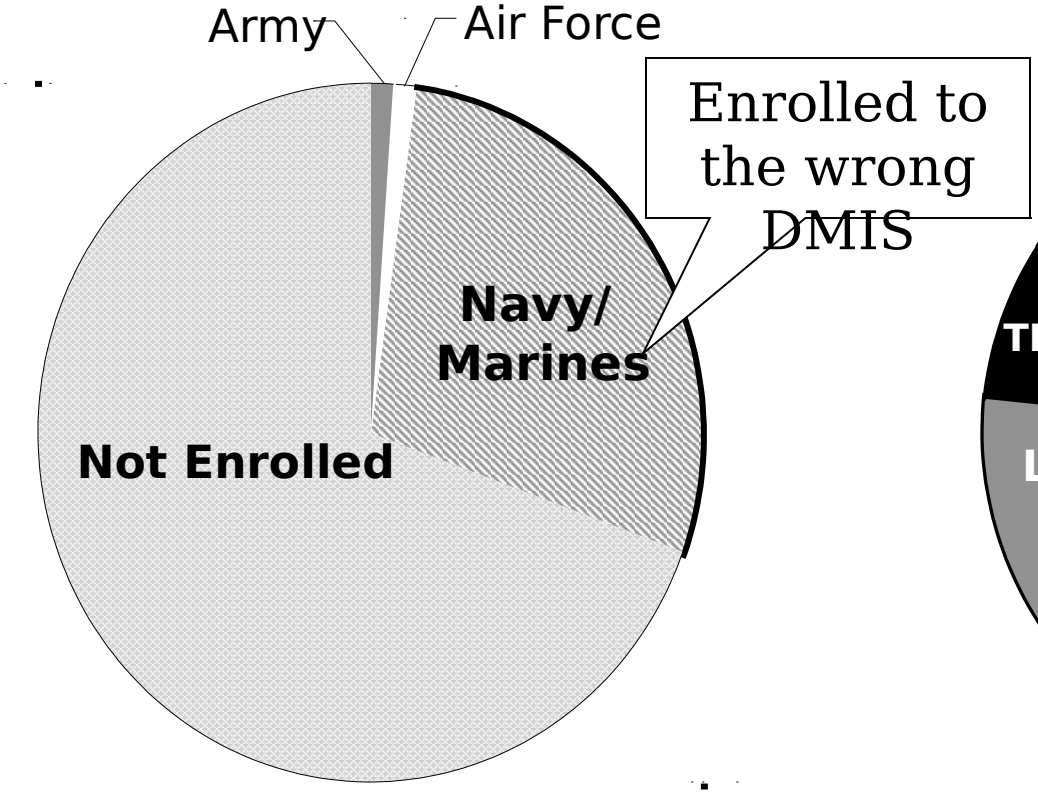


Access: EMD Acuity

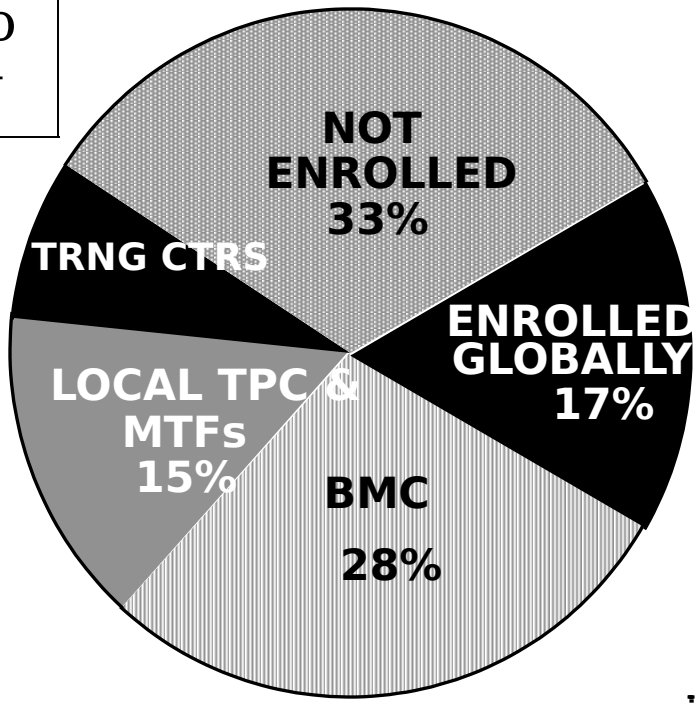


Access: Enrollment

Sample OP UIC Enrollment

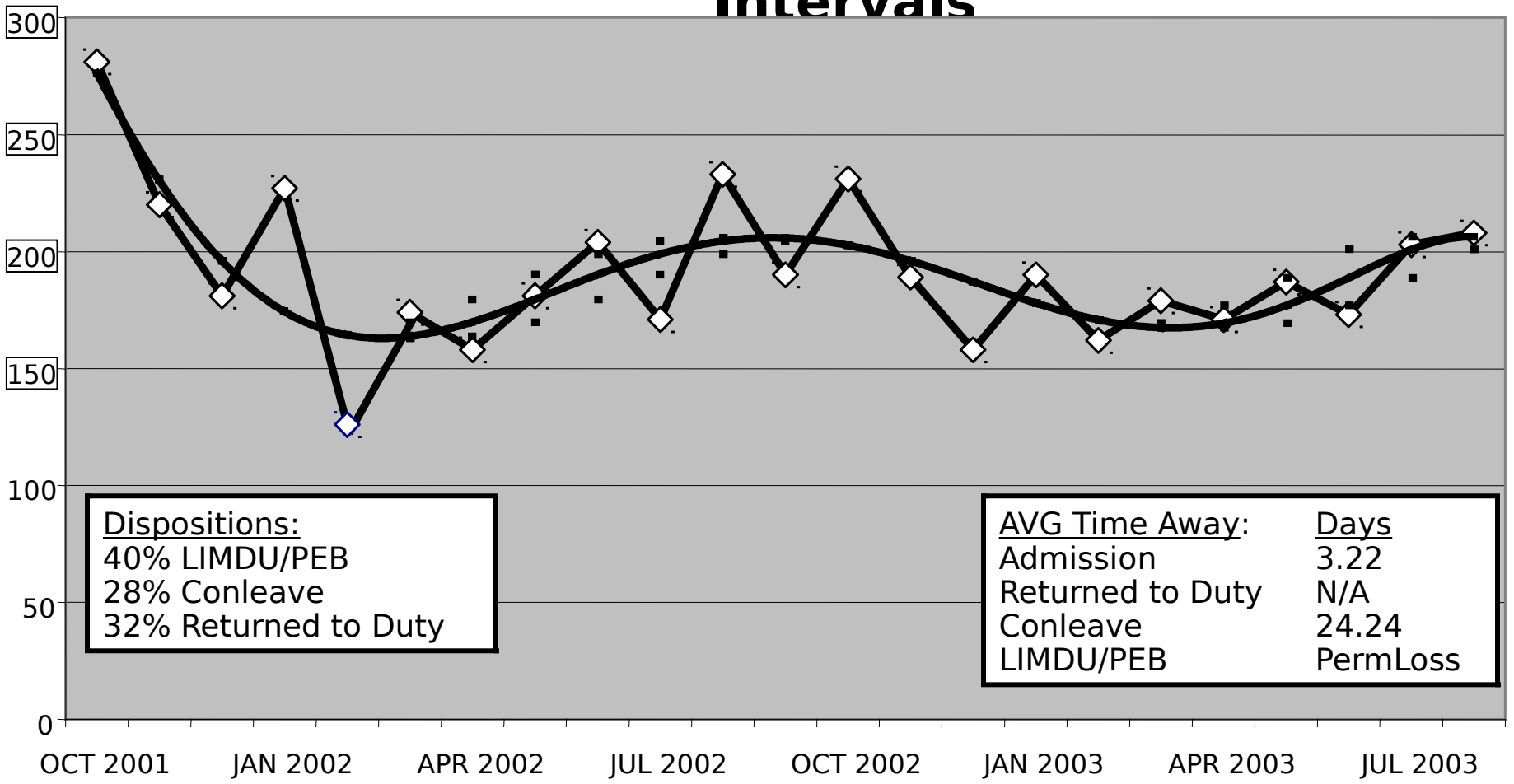


BMC Visits FY01



COST: Readiness

Impact - Personnel Admissions at Critical Intervals



Quality

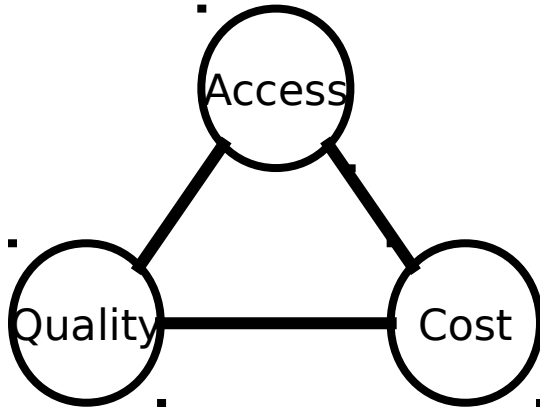
- PCP Patient Population Management – No continuity of care & no return information on patient encounters
- Specialty Care and Referral Management – Redundant processes/ poorly coordinated referral
- Case Management - Complicated or cross regional cases are difficult to coordinate and resolve

Magnitude

The gap: ~250,000 Naval Operational Forces not properly enrolled:

- Access is often provided at the most expensive level of care
- A uniform benefit is not provided, i.e. benefit information, billing, and PCP Training & Ed.
- At present, limited integration of the Operational and Direct Care System
- Optimization of primary and specialty care provided to ADSM has not been achieved

How does this relate to Readiness, Integration & Optimization?



- **Readiness** – lost man hours & permanent personnel losses at critical points in deployment cycles
- **Integration** – Two separately funded healthcare sub-systems
  - No mandate for the coordination & control of care between the direct care system and the operational force PCP
- **Optimization -** Direct Care System is unable to program resources to support an unknown cost of readiness
  - Healthcare system is inefficient - uncontrolled access, affecting the TRICARE MCSC

Business Practices or Processes Impacted

- System Integration & Readiness
  - MTF enrollment practices for Operational Forces
  - Specialty/Referral Care
  - Operation Force Liaison Programs
- System Optimization
  - MTF Case Management
  - CHCS - Workload capture of support provided to operational forces
  - Health Plan cost accounting/expenses for operational forces.

Short Term Objectives:

Endorsement of Policy Letter:

- Change in the enrollment process to an automated system transparent to the member
- Validation of the operational unit senior medical department representatives as Primary Care Providers equivalent to their MTF PCM counterparts

Midterm Objectives:

- BUPERS mandate DEERS validation is a personnel function at check-in
- Approval of OPNAV Enrollment & Assignment Instruction for Operational Forces
- Revise Operation Force Department/Fleet Liaison Instruction to include more detailed training regarding the Enrollment process & the TRICARE benefit

Long Term Objectives:

- Seamless, transparent integration of two previously parallel medical systems
- Uniform benefit for all beneficiaries

Health care on the waterfront is a "Total Force Concept"

Force medical is the catalyst for integration, and an advocate for sailors, their families & shipboard medical departments.

Naval Hospitals

Branch Medical Clinics

Force Medical

Force Medical

Medical ISICs

Force Medical

FLEET FORCES COMMAND

SURFOR

NAVMEDLOGCOM | BUMED | OPNAV 931 | BUPERS | NEHC/NEPMU